STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – Nelson J. Sabatini, Secretary

MEMORANDUM

ATTENTION

To: Private Duty Nursing Providers
Model Waiver Providers

From: Nancy Cutair
Division of Nursing Services

Re: **HIPAA IMPLEMENTATION – IMPORTANT!**

Date: December 18, 2003

This memorandum serves as follow-up to my prior memorandum dated October 10, 2003 concerning our efforts to implement HIPAA requirements and the HIPAA training classes conducted by the staff of the Division of Nursing Services (DONS).

"T" Codes May Now Be Preauthorized:

- **Preauthorization requests for private duty nursing and shift home health aide services using the new HIPAA compliant "T" codes for dates of service on or after January3, 2004 may now be made.** These codes are noted on attachment A.

Additional Information We Need From You:

We need to know two (2) new pieces of information when you call for preauthorization of services. This new information is:

- **Providers must advise the DONS under which program the client is receiving services. Specifically, you will need to advise the staff whether the client is a Model Waiver, Rare and Expensive Case Management (REM) or fee for service client.**

- **Providers must advise the DONS of all individuals who are sharing nursing or aide services.**

We are requesting all agencies to review their client list and provide the DONS' staff with a written list indicating the names and Medicaid numbers of all clients served by your agency who share nurses or aides. We are requesting you to provide this information to us no later than **January 15, 2004**. Please mail the information to the following address:

Carla Rivers, RN
Division of Nursing Services
Office of Health Services
Room 130
201 West Preston Street
Baltimore, MD 21201

Billing Updates:

- A **REVISED** set of billing instructions will be mailed to you shortly. This set of instructions contains a few changes that were not included in the set of billing instructions you received during the HIPAA class conducted by Carla Rivers, RN of my staff.
- All agencies must submit a signed **Submitter Identification Form** to Medicaid whether they bill electronically or via paper. This form is required for you to continue to access Medicaid's Eligibility Verification System (EVS). This form was provided to you during the HIPAA training session you and/or your staff attended.
- The new billing form is the CMS 1500. You may obtain a copy of this form at the following website:
  www.cms.hhs.gov/providers/edi/cms1500.pdf
  This form may be copied and submitted to the Medicaid Program for private duty nursing and shift home health aide services provided to Medicaid participants. You may also buy the CMS 1500 form at Staples, Office Depot, etc.
- Attachment B reflects a sample CMS 1500 form demonstrating those areas that you must complete when billing Medicaid for the private duty nursing or shift home health aide services which your agency has provided to Medicaid participants.
- **You must use the "TT" modifier in all instances in which clients share nursing or aide services.**
- **If you plan to submit electronic claims to Medicaid, either directly or through a billing service, you must submit to the Medicaid Program a signed Submitter Identification Form and Trading Partner Agreement as well as complete testing prior to such billings. These forms were provided to you during the HIPAA training session you and/or your staff attended.**

We would like to thank you for your patience and cooperation during this lengthy and major project and look forward to working with you to ensure a smooth and painless

transition to the new HIPAA compliant system. If you have any questions, please do not hesitate to call Carla Rivers, RN of my staff at (410) 767-1448. Thank you.

Attachments

Cc: Carla Rivers, RN
Samuel Colgain, III

ATTACHMENT A

HIPAA COMPLIANT PDN/AIDE CODES

Service	Procedure Code	Description of Code
Assessment	T1001	RN up to 15 minutes
1 nurse/1 recipient	T1002	RN up to 15 minutes
1 nurse/1 recipient	T1003	LPN up to 15 minutes
1 nurse/2 recipients	T1002	RN up to 15 minutes
1 nurse/2 recipients	T1003	LPN up to 15 minutes
1 aide/1 recipient 1 aide/2 recipients	T1004	Aide up to 15 minutes

ATTACHMENT B

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

PICA ☐☐☐ PICA ☐☐☐

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, John D. Jr.	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Smith, John D. Sr.	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER K
a. OTHER INSURED'S POLICY OR GROUP NUMBER 10201040401	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN 021254333	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE 021031520		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 330.0 2. 343.2 3. ____ 4. ____		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER N0035404

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 03 04		12		T1003	TT	1	480 00	64				
2 01 05 04		12		T1002		1	480 00	64				
3 01 06 04		12		T1003		1	480 00	64				
4 01 07 04		12		T1003		2	360 00	48				
5 01 09 04		12		T1003		2	360 00	48				
6 01 12 04		12		T1003		2	480 00	64				

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
	157	☐ YES ☐ NO	$ 2,640 00	$	$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
01/31/04 SIGNED DATE		Dr. Jay Jones 2100 S. Charles Street, Suite 11 Baltimore MD 212101 PIN# GRP# 021254333

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)